

Revalidating a Contract or Updating a Profile as a Group Provider with Nevada Medicaid





Objectives



Objectives:

- Review the Provider Enrollment Webpage, including:
 - Provider Enrollment Checklists
 - The Online Provider Enrollment User Manual
 - Provider Revalidation Report
 - Changes to Provider Information
 - Contact Information for Provider License Updates and Voluntary Terminations
- Revalidate with Nevada Medicaid as a Group Provider via the Electronic Verification System (EVS)
- Cover Resources
- Contact Nevada Medicaid

Provider Enrollment Webpage

Provider Enrollment Webpage

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

Contact Us DHCFP Home

Search

Home Providers EVS Pharmacy Prior Authorization Claims Quick Links Calendar

Announcements Latest News

- [Web Announcement 1911](#)
Compounded Medications Require Prior Authorization Effective June 3, 2019
- [Web Announcement 1910](#)
New and Updated Pharmacy Prior Authorization Forms
- [Web Announcement 1909](#)
Medicaid Services Manual Chapter 1200 Updated
- [Web Announcement 1908](#)
Notification Regarding Provider Signatures on Prior Authorization Forms
- [Web Announcement 1907](#)
Attention Provider Types 15 (Registered Dietitian), 30 (Personal Care Aide – Provider Agency), 54 (Targeted Case Management), 83 (Personal Care Aide – Intermediary Service Organization): DHCFP Rate Reviews per Assembly Bill 108

[View All Web Announcements](#)

Welcome

Modernization Known System Issues

Click here to review the Known System Issues, Resolutions and Workarounds for common issues.

Please refer to the Modernization Known Issues List prior to contacting Nevada Medicaid, as many common problems and their resolutions are listed.

Nevada Medicaid

Welcome to the Nevada Medicaid and Nevada Check Up Provider Web Portal. Through this easy-to-use internet portal, healthcare providers have access to useful information and tools regarding provider enrollment and revalidation, recipient eligibility, verification, prior authorization, billing instructions, pharmacy news and training opportunities. The notifications and web announcements keep providers updated on enhancements to the online tools, as well as updates and reminders on policy changes and billing procedures.

Thank you for your participation in Nevada Medicaid and Nevada Check Up.

Notifications

Known Modernization System Issues-Click HERE

Paper claims are no longer accepted by Nevada Medicaid. Please refer to [Web Announcement 1733](#) and [Web Announcement 1829](#) for additional information.

Attention Providers Using the Authorization Criteria Function: Results that return prior authorization (PA) requirements are accurate. For results that return "There are no records found based on the search criteria," there may be a PA requirement if limits have been exceeded. To verify PA requirements, please refer to the Medicaid Services Manual (MSM) Chapter for your service type at [dhcfnv.gov](#) and the Billing Guide for your provider type at [www.medicaid.nv.gov](#).

Provider Links

- [Billing Information](#)
- [E-Prescribing Forms](#)
- [Provider Enrollment](#)
- [Provider Newsletters](#)
- [Provider Training](#)

Scheduled Site Maintenance

During the scheduled site maintenance window the Provider Web Portal will be unavailable. The table below shows the regularly scheduled maintenance window. All times will be in the Pacific time zone.

Day	Time
Monday - Friday	12:00AM - 12:30AM

The Nevada Medicaid website is designed to assist providers with understanding the Nevada Medicaid program and includes information regarding enrollment, billing, access to the Electronic Verification System (EVS) and additional resources to assist providers.

Link: www.medicaid.nv.gov

Provider Enrollment Webpage, continued

The screenshot shows the Nevada Department of Health and Human Services Provider Portal. The top navigation bar includes links for Providers, EVS, Pharmac, Prior Authorization, Claims, Quick Links, and Calendar. A search bar is located on the right. The main content area features a large banner for 'Modernization Known System Issues' with a call to action to click here to review the Known System Issues, Resolutions and Workarounds for common issues. The left sidebar contains a 'Providers' menu with options like Announcements/Newsletters, Billing Information, Electronic Claims/EDI, E-Prescribing, Forms, NDC, Provider Enrollment, and Provider Training. The right sidebar includes a 'Notifications' section with a link to 'Known Modernization System Issues' and a 'Provider Links' section with links to Billing Information, E-Prescribing, Forms, Provider Enrollment, Provider Newsletters, and Provider Training. A 'Scheduled Site Maintenance' section is also visible at the bottom right.

Providers • EVS • Pharmac • Prior Authorization • Claims • Quick Links • Calendar

Announcements/Newsletters
Billing Information
Electronic Claims/EDI
E-Prescribing
Forms
NDC
Provider Enrollment
Provider Training

Featured Links
Authorization Criteria
DHCFP Home
EDI Information
EVS User Manual
Modernization Project
Online Provider Enrollment
Provider Login (EVS)
Prior Authorization
Search Fee Schedule
Search Providers
Claims

Providers • EVS • Pharmac

Announcements/Newsletters
Billing Information
Electronic Claims/EDI
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Provider Links
Billing Information
E-Prescribing
Forms
Provider Enrollment
Provider Newsletters
Provider Training

Scheduled Site Maintenance
During the scheduled site maintenance window the Provider Web Portal will be unavailable. The table below shows the regularly scheduled maintenance window. All times will be in the Pacific time zone.
Monday - Friday

Highlight Providers from the top tool bar and select Provider Enrollment from the drop-down menu or select Provider Enrollment from the Provider Links section on the right-hand side of the page.

Provider Enrollment Webpage, continued

Provider Enrollment

Effective January 12, 2019, all providers will be required to submit their Provider Enrollment Applications electronically via the Online Provider Enrollment (OPE) Tool at <https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx>, **A** **B** enrollment applications will no longer be accepted with the go-live of the new modernized Medicaid Management Information System (MMIS). Please continue to review the modernization-related web announcements at <https://www.medicaid.nv.gov/providers/Modernization.aspx> for further details.

Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. This page contains all of the information and forms you will need to become a Nevada Medicaid provider. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8a.m. to 5p.m. Monday through Friday.

Effective 12/1/2015, access [Online Provider Enrollment](#) for individual, group or OPR enrollments. **C**

Provider Documentation Reminders: (See [Web Announcement 1125](#) for reminders that will assist providers in adhering to the documentation responsibilities required of each Nevada Medicaid/Nevada Check Up provider.)

All enrollment documents including attachments require an *original* signature from the provider or an authorized representative (use dark blue or black ink).

The Provider Enrollment webpage contains all necessary information in order to properly enroll in Nevada Medicaid, including:

- A. Access to the Online Provider Enrollment (OPE) tool
- B. Link to modernization announcements
- C. Additional link to the OPE tool

Required Enrollment Documents – Enrollment Checklists

Required Enrollment Documents

- [Provider Enrollment Information Booklet](#): UPDATED FOR MMIS MODERNIZATION IMPLEMENTATION. All providers will need the information contained in this booklet which includes common enrollment questions and information about out-of-state providers and provider groups.
- [Enrollment Checklists](#): Copies of certain documents must be included with your Provider Enrollment Packet (e.g., copy of professional certification, proof of insurance, background check). The Enrollment Checklists show required documentation for each provider type.
- [Business Associate Addendum \(NMH-3820\)](#): This document must be signed and submitted with your Provider Enrollment/Revalidation Packet if it is listed on the Provider Enrollment Checklist for your Provider Type and when requested by the Division of Health Care Financing and Policy (DHCFP) or Nevada Medicaid.
- [Advance Directives Compliance Self-Evaluation & Certification \(NMH-3827\)](#): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.
- [Civil Rights Compliance Self-Evaluation & Certification \(NMH-3828\)](#): This form must be completed and submitted to DHCFP if it is listed on the Provider Enrollment checklist for your Provider Type.

Enrollment Checklists are separated out by Provider Type In order to determine the documentation that is required to accompany the application, select Enrollment Checklists. All Provider Types require the checklist to be followed.

Required Enrollment Documents – Enrollment Checklists, continued

Provider Enrollment Checklists

To see which documents must be submitted with your Provider Enrollment Packet, click the name of your provider type(s) in the list below. If your provider type is not in the list below, please contact the Provider Enrollment Unit at (877) 638-3472 for requirements.

Note: Out of state providers must also submit proof of Medicaid eligibility in the state that services are/were rendered.

Provider Type	Title	Updated Date
10	Outpatient Surgery, Hospital Based	04/20/16
11	Hospital, Inpatient	02/18/16
12	Hospital, Outpatient	02/18/16
13	Psychiatric Hospital, Inpatient	04/20/16
14	Behavioral Health Outpatient Treatment	n/a
15	Registered Dietitian	12/15/17
16	Intermediate Care Facilities for Individuals with Intellectual Disabilities, Public	04/20/16
17	Special Clinics	n/a
19	Nursing Facility	04/20/16
20	Physician, M.D., Osteopath, D.O.	08/25/17
21	Podiatrist	08/25/17
22	Dentist	01/03/13
23	Hearing Aid Dispenser & Related Supplies	08/25/17
24	Advanced Practice Registered Nurse	08/30/17
25	Optometrist	08/25/17
26	Psychologist	07/19/16
27	Radiology and Non-invasive Diagnostic Centers	12/01/14
28	Pharmacy	04/28/17
29	Home Health Agency	07/05/17

Each Provider Type will have access to a Provider Type specific Checklist.

Locate the appropriate Provider Type and select the Title of the Provider Type to open the checklist.

It is important to review each item listed on the Checklist as the information will be different for each Provider Type.

Online Provider Enrollment User Manual

Online Provider Enrollment User Manual

- [Chapter 1: Getting Started](#)
- [Chapter 2: Initial Enrollment Application](#)
- [Chapter 2 Addendum: Ownership & Relationships Example](#)
- [Chapter 3: Revalidation and Updates](#)

The Online Provider Enrollment User Manual will contain pertinent information for using the OPE tool and provide additional details regarding each question that is contained within the application.

Chapter 1: Getting Started – Overview of how to use the OPE tool

Chapter 2: Initial Enrollment Application – Provides step-by-step instructions on how to complete an initial application

Chapter 2 Addendum: Ownership & Relationships Example – Provides additional clarification for users when answering the Ownership Disclosure and Relationship questions

Chapter 3: Revalidation and Updates – Instructions on how to revalidate or make changes to a provider profile through the Electronic Verification System (EVS)

Revalidation Report

Revalidation Report

- **Provider Revalidation Report:** The Nevada Medicaid Provider Revalidation Report lists each provider and the date their next revalidation is due. To avoid contract termination, your revalidation application must be processed and approved prior to the revalidation due date.

The Provider Revalidation Report is a PDF document that allows any user to view a National Provider Identifier (NPI) to determine the date that their contract will need to be revalidated. Providers are required to revalidate with Nevada Medicaid every five (5) years. The only exception is that Durable Medical Equipment (Provider Type 33) providers must revalidate every three (3) years.

Viewing the report will assist providers with making sure that their contract with Nevada Medicaid does not terminate. If a contract terminates due to a provider not submitting a revalidation, the provider will then need to complete and submit a brand new application. If a provider's contract terminates and the provider attempts to bill for dates of service that happen after their termination date, those particular claims will be denied.

Changes to Provider Information

Changes to Provider Information

Changes to any information presented on your enrollment documents must be reported to Nevada Medicaid within five business days.

- To complete changes online, please login to the [Secure Web Portal](#), and choose "Revalidate-Update Provider".
- To report a change in business ownership, resubmit a completed Provider Enrollment Application.
- Provider license updates and voluntary terminations can be mailed or e-mailed to Nevada Medicaid for processing

As of February 1, 2019, any provider that is already enrolled in Nevada Medicaid can make changes to their provider profiles via the EVS secure Provider Web Portal. For instructions, please review Chapter 3 (Revalidation and Updates) of the Online Provider Enrollment User Manual that was previously discussed and can be located on the Provider Enrollment webpage of the Medicaid website.

Contact Information for Provider License Updates and Voluntary Terminations

Contact Information for Provider License Updates and Voluntary Terminations Only

Mail completed provider license updates and/or voluntary terminations to Nevada Medicaid, Provider Enrollment Unit, P.O. Box 30042, Reno, NV 89520-3042 or E-mail: nv.providerapps@dx.com for processing

Should a provider wish to submit their updated license information or if a provider will be terminating a contract, that information is to be emailed to: nv.providerapps@dx.com or mailed to the P.O. Box. It is important to note that any documentation besides an updated license or a contract termination will not be reviewed and processed via this email address. Changes to a provider profile will **not** be accepted via email and those changes must be made via the EVS secure Provider Web Portal.

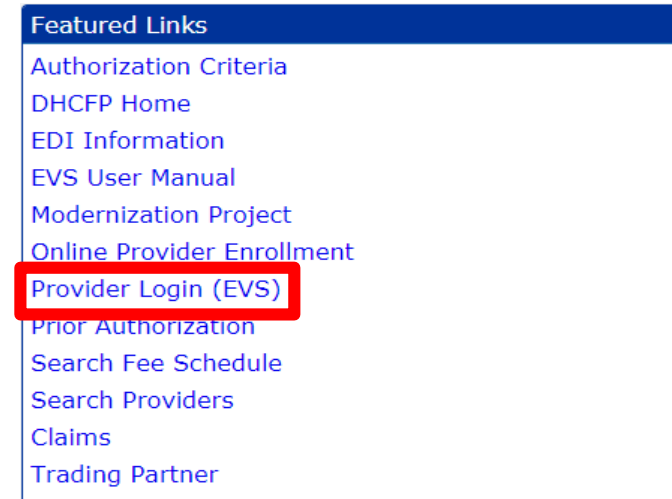
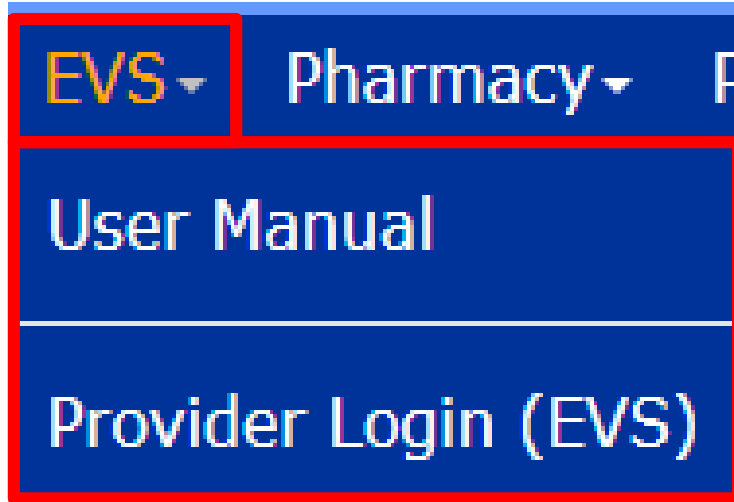
Revalidating a Contract or Updating a Provider Profile as a Group with Nevada Medicaid via the EVS Provider Web Portal

Revalidation Information

- Revalidations are required to be submitted every five (5) years. The exception is for Provider Type 33 (DME providers), who are required to revalidate every three (3) years.
- Providers cannot ask for retro prior authorizations if their contract terminates.
- Providers who miss the revalidation date deadline will be required to complete an Initial Application and submit to Nevada Medicaid.
- The matrix below lists resources available to providers should their contract expire without revalidating timely.

MAIN MENU	SUB MENU / LINKS	DURATION OF TERMINATION ACCESS (1 YEAR)
Eligibility	Eligibility Verification	No
Claims	Search Claims, Submit Claims, Search Payment History & Treatment History	Yes
Care Management	Create Authorization, View Status, Maintain Favorite Providers, Authorization Criteria	No
File Exchange	Upload Files	Yes
Resources	Search Providers, Search Fee Schedule, Downloads, Report Download	Yes
My Home (* Connects to external links)	My Profile (Change Phone/Email), My Profile (Change Site Key Token/Password), Manage Accounts (Add/Remove Delegate), Manage Accounts (Add/Remove Trading Partner), Search Payment History, Contact Us, Secure Correspondence	Yes
My Home (* Connects to external links)	Member Focused Viewing, Revalidate-Update Provider, Pharmacy PA *, PASRR *, EHR Incentive Program *, EPSDT *, Presumptive Eligibility *	No

Electronic Verification System



The EVS secure Provider Web Portal may be accessed from a variety of different locations, including the top blue tool bar > EVS > Provider Login (EVS) or the Featured Links (left-hand side of every page).

EVS Login

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Login](#)

Home

Home

Login ?

*User ID

[Log In](#)


[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can inquire on the status of their claims and payments, inquire on a patient's eligibility, process prior authorization requests and access Remittance Advices. In addition, healthcare providers can use this site for further access to contact information for services provided under the Nevada Medicaid program.



[Website Requirements](#)

Prior Authorization Quick Reference Guide [\[Review\]](#)

Provider Web Portal Quick Reference Guide [\[Review\]](#)

Web Announcements

[Web Announcement 1912](#)
Attention Provider Type 33 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies): Claims May Be Submitted with Two Payment Modifier Combinations

[Web Announcement 1911](#)
Compounded Medications Require Prior Authorization Effective June 3, 2019

[Web Announcement 1910](#)
New and Updated Pharmacy Prior Authorization Forms

[Web Announcement 1909](#)
Medicaid Services Manual Chapter 1200 Updated

[Web Announcement 1908](#)
Notification Regarding Provider Signatures on Prior Authorization Forms

[View More Web Announcements](#)

Featured Links

[Authorization Criteria](#)

[DHCFP Home](#)

[EDI Enrollment Forms and Information](#)

[EVS User Manual](#)

[Search Fee Schedule](#)

[Search Providers](#)

After the user selects EVS Login, they will then be required to Login.

Input the registered User ID and select Log In. If the user has forgotten their User ID, select the Forgot User ID? Link.

Login ?

*User ID

[Log In](#)

[Forgot User ID?](#)


[Register Now](#)

[Where do I enter my password?](#)

EVS Login, continued

Home

Home > Challenge Question

**Computer and Challenge Question**

Site Key

The HealthCare Portal uses a personalized site key to protect your privacy online. To use a site key, you are asked to respond to your Challenge question the first time you use a personal computer, or every time you use a public computer. When you type the correct answer to the Challenge question, your site key token displays which ensures that you have been correctly identified. Similarly, by displaying your personalized site key token, you can be sure that this is the actual HealthCare Portal and not an unauthorized site.

If this is your personal computer, you can register it now by selecting: **This is a personal computer. Register it now.**

If this is not your personal computer, such as a public computer, select: **This is a public computer. Do not register it.**

Answer the challenge question to verify your identity.

Challenge Question In what city were you born?

***Your Answer**

[Forgot answer to challenge question?](#)

Select

☐ This is a personal computer. Register it now.

☒ This is a public computer. Do not register it.

Continue

After the User ID has been entered, the user will then be prompted with a Challenge Question.

Answer the Challenge Question and indicate whether a personal or public computer is being used. If Personal is selected, the user will not have to answer a challenge question the next time they login.

EVS Login, continued

Home

[Home](#) > [Challenge Question](#) > Site Token Password


Confirm Site Key Token and Passphrase

Confirm that your site key token and passphrase are correct.

If you recognize your site key token and passphrase, you can be more comfortable that you are at the valid HealthCare Portal site and therefore is safe to enter your password.

Make sure your site key token and passphrase are correct.

If the site key token and passphrase are correct, type your password and click **Sign In**.
If this is not your site key token or passphrase, do not type your password.
Call the [customer help desk](#) to report the incident.

Site Key: 

Passphrase Cubs

***Password**

[Sign In](#)

[Forgot Password?](#)

After the Challenge Question is successfully answered, the user will then be able to view the Site Key and Passphrase. This information was created when their portal account was created.

Input the correct password and select Continue.

If the user has forgotten the correct password, select the Forgot Password reset link. This will allow users to reset their own password and eliminates the need to contact the Nevada Medicaid Customer Service Call Center.

Revalidation

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) | [Logout](#)

My Home | **Eligibility** | **Claims** | **Care Management** | **File Exchange** | **Resources** | **Switch Provider**

My Home

Delegate for: FieldTeam | Role IDs

Provider

Welcome
Name
Provider ID
Location ID

► [My Profile](#)
► [Switch Provider](#)

Provider Services

- [Member Focused Viewing](#)
- [Search Payment History](#)
- [Revalidate-Update Provider](#)
- [Pharmacy PA](#)
- [PASRR](#)
- [EHR Incentive Program](#)
- [Presumptive Eligibility](#)

Welcome Health Care Professional!

[Contact Us](#)

[Secure Correspondence](#)

All Claim Inquiries should be submitted to the following Address:
Nevada Medicaid Administration
P.O.Box 30042
Reno, NV 89520-3042

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and search for claims, payment information, and access Remittance Advices, our secure site provides access to eligibility, answers to frequently asked questions, and the ability to process authorizations.

[Prior Authorization Quick Reference Guide \[Review\]](#)
[Provider Web Portal Quick Reference Guide \[Review\]](#)

After the user has successfully logged in, locate and select Revalidate-Update Provider from the Provider Services section on the left-hand side of the page.

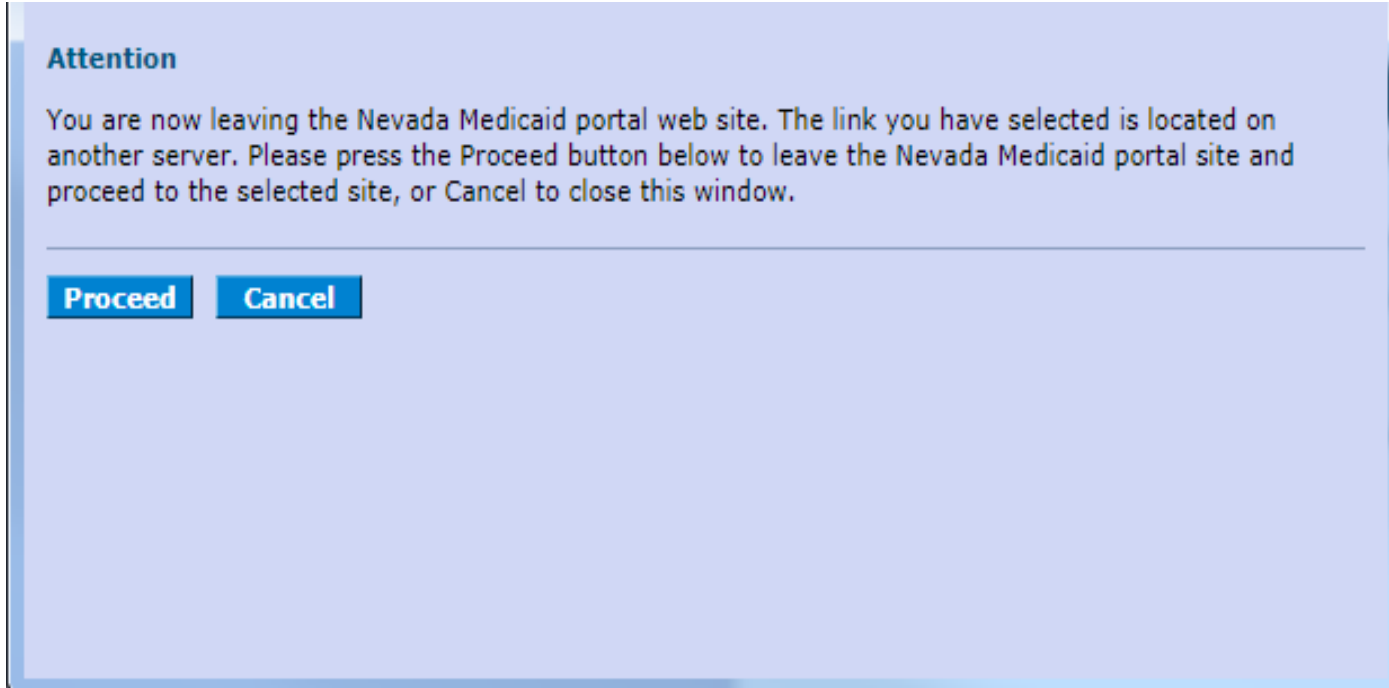
- Provider Services**
- [Member Focused Viewing](#)
 - [Search Payment History](#)
 - [Revalidate-Update Provider](#)
 - [Pharmacy PA](#)
 - [PASRR](#)
 - [EHR Incentive Program](#)
 - [Presumptive Eligibility](#)

Revalidation, continued

Provider Locations ?						
Duplicate providers may appear in the results since a unique row is created for each specialty.						
						Total Records: 1
Provider Name	Provider Type	Address	City	State	Zip Code	Action
	Physician, M.D., Osteopath, D.O.					Revalidate Provider OR Update Provider

Once the Revalidate-Update link is selected, the user will be brought to a page in which they can view all associated providers. The user will need to choose the correct provider and click on the Revalidate Provider link from the Action column.

Revalidation, continued



The user will be prompted with a pop up asking if they would like to leave the page they are on. Select Proceed in order to continue with the revalidation process.

The user will then be directed to the Online Provider Enrollment (OPE) tool to complete the revalidation.

Welcome Page



Nevada Department of Health and Human Services

Division of Health Care Financing and Policy Provider Portal



[Contact Us](#)
[Frequently Asked Questions](#)



Provider Enrollment

[Provider Enrollment](#) > Provider Enrollment Application


Provider Enrollment: Welcome	
Welcome	Welcome to the Online Provider Enrollment System
Request Information	Thank you for your interest in the Nevada Medicaid and Nevada Check Up Program. To bill for services rendered to Nevada Medicaid recipients, you must enroll as a Nevada Medicaid Provider. DXC Technology is the current fiscal agent for the Nevada Medicaid and Nevada Check Up program. Hereafter, DXC Technology is referred to as Nevada Medicaid.
Specialties	All of the materials within this document must be completed and submitted to Nevada Medicaid for your request to be processed. A checklist of required documentation has been provided for your convenience. Please review the Provider Information Enrollment Booklet for additional information.
Addresses	Submission of incomplete materials will delay your request. In addition to required documentation, additional supporting documentation can be uploaded with your application if necessary. If your responses to any questions on this enrollment application did not fit into the field on the page, type the question and response and upload the documentation using Other as the attachment type on the Attachments page of this online application. All documents must be uploaded at the time of provider enrollment forms submission in order for your application to be considered complete. Please retain copies of your materials for your records. You will receive written notification upon approval or denial of your request.
Provider Identification	
Other Information	
Ownership & Disclosure	
Agreement	
Attachments	
Summary	
	Urgent/Emergency Enrollment
	If you are requesting urgent/emergency enrollment as an individual provider and have a separate billing provider, they will need to enroll with Nevada Medicaid as a billing provider. Once they are enrolled, you will then need to be linked to the group for claims to process appropriately. The group can be a fully enrolled provider or an urgent/emergency provider.
	If you are requesting urgent/emergency enrollment as a group provider, and have a separate servicing provider, they will need to enroll with Nevada Medicaid as individual provider and be linked to the group for claims to process. The individual can be a fully enrolled provider or an urgent/emergency provider.
	You can verify if a provider is enrolled using the Provider Search tool https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx
	Once both the servicing and billing provider are enrolled you will need to submit the claim for payment. Billing instructions can be found on https://www.medicaid.nv.gov/providers/BillingInfo.aspx .
	If you have questions concerning enrollment, contact Provider Enrollment at (877) 638-3472 (select options for "Provider Enrollment") between 8:00 a.m. and 5:00 p.m. PT Monday through Friday.
	Please click the "Continue" to proceed.
	<div>Continue Cancel</div>

The Welcome Page provides relevant information regarding enrolling in the Nevada Medicaid program, as well as:

- (A) Table of Contents. Table of Contents will always be available and once a user has completed a section, the Table of Contents will hyperlink each completed section of the application in case a user needs to go back and update information.
- (B) Contact Us and FAQ links.

In order to continue with the application, select Continue.

Request Information

Provider Enrollment: Request Information		?
Welcome	Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later". The contact person will potentially be contacted to answer any questions regarding the information provided in this request.	
 Request Information	* Indicates a required field.	
Specialties		
Addresses		
Provider Identification		
Other Information		
Initial Enrollment Information		
Enrollment Type Group		
Provider Type 20-Physician, M.D., Osteopath, D.O.		

When revalidating a provider, if the provider’s original application was completed online, there may be information that is already pre-populated for the revalidation process. If the provider originally submitted a paper application and did not complete an application online, the information will not be populated and the user will be required to complete all available fields.

Request Information, continued

Provider Information	
A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.	
*Federal Tax ID ⓘ	<input type="text" value="2"/> <input type="text" value="8"/>
Are you currently enrolled as a Provider? Yes	

Users will then need to verify that the Federal Tax ID is still correct and there is no response required for the question regarding already being enrolled as a Provider.

Request Information, continued

Contact Information

This contact information is required for correspondence regarding the associated application. Provide the appropriate contact person and information who can assist with the request.

*Last Name

*First Name

TIFFNEY

*Telephone Number

775

Telephone Number Extension

Fax Number

775

*Contact Email

*Confirm Email Address

*Preferred Method of Communication

Continue

Finish Later

Cancel

The contact information first and last name and telephone number will already be pre-populated. The Contact Email will be required as well as confirming the contact email address.

If there is any information missing, complete the fields as necessary.

Once this section has been completed,
select Continue.

Specialties, continued

Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty. See the [Provider Enrollment Information Booklet](#) for the complete list of provider types and specialty codes. If a provider does not have a specialty, please enter the specialty NO SPECIALTY. You can also enter an optional board certification for each specialty.

* Indicates a required field.
✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

	Specialty	Action
<input type="checkbox"/>	<input checked="" type="checkbox"/> Allergy	
<input type="checkbox"/>	Anesthesiology	Remove
<input type="checkbox"/>	Click to add specialty.	

Continue **Finish Later** **Cancel**

If the provider has more than one specialty, select the + symbol and follow previous steps.

If the user selects an incorrect specialty, select Remove from the Action column.

The first specialty selected will be the primary specialty.

Once all specialties are added, select Continue.

Provider Addresses

Provider Addresses

The service address is required. The service address is the physical location of the practice/business/facility where services will be rendered. **This must be a street address and NOT a post office box.**

Paper checks will be mailed to Pay-To address while Electronic Funds Transfer (EFT) testing is performed. If you do not supply a Pay-To address, paper checks will be mailed to the service address.

Nevada Medicaid will mail written correspondence, excluding remittance advices, to Mail-To address. If you do not supply a Mail-To address, written correspondence will be mailed to the service address.

Nevada Medicaid recommends using electronic instead of paper Remittance Advices (RAs) for faster account reconciliation. However, if you wish to receive paper RAs and have them mailed to an address different from the addresses listed above, please complete the Remittance Advice address.

Enter each type of valid provider address including location(s) where a provider renders services, as well as location(s) used for billing and payment.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Collapse the row and click the "Remove" link to remove the entire row or "Copy" link to copy the entire row.

	Type	Street	City	State	Action
+	Service	5560 KIETZKE LN	RENO	Nevada	Copy Remove
+	Pay-To	BLDG A	RENO	Nevada	Copy Remove
+	Click to add address.				

Continue

Finish Later

Cancel

This section will allow the user to verify all address information for the provider.

Service Address must be a physical address and cannot be a P.O. Box.





Pay To Address is the address that Nevada Medicaid will send paper checks until Bank Information is approved for Electronic Funds Transfer.

Mail To Address is the address that Nevada Medicaid may send written correspondence.

Remittance Advice address is the address that Nevada Medicaid will send RA's that are older than six (6) months. All other RA's are available electronically.

When the user is ready to input or edit address information to the application, select the +.

Provider Addresses, continued

Type	Street	City	State	Action
<input type="checkbox"/> Click to collapse.				
*Address Type 	<input type="text"/>			
*Street	<input type="text"/>			
	<input type="text"/>			
*City	<input type="text"/>			
*Zip+4 	<input type="text"/>			
Email Address 	<input type="text"/>			
	*State <input type="text"/>	*County <input type="text"/>		
	Confirm Email Address 	<input type="text"/>		
Telephone Number Office	<input type="text"/>	Telephone Number Extension	<input type="text"/>	
Telephone Number Fax	<input type="text"/>			
Telephone Number TDD	<input type="text"/>			
Contact Name	<input type="text"/>			
Telephone Number Contact	<input type="text"/>	Telephone Number Extension	<input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>				

Address Type: Select from drop-down menu (Service, Mail-To, Pay-To, Remittance Advice)

Street: Street Address. For service address, this must be a physical address. All other addresses can either be a physical address or a P.O. Box.

City: City

Zip+4: Zip Code. User can locate the additional 4 digits by running a post office address search or inputting 4 zeroes.

State: Select the state the address is located in from drop-down menu.

County: Select the county the address is located in from drop-down menu.

Provider Addresses, continued

Type	Street	City	State	Action
<input type="checkbox"/> Click to collapse.				
*Address Type	Service			
*Street	9850 Double R Blvd			
	Suite 102			
*City	Reno			
*State	Nevada			
*Zip+4	895210000			
*County	Washoe			
Verify Address				
Email Address	Confirm Email Address			
Telephone Number Office	Telephone Number Extension			
Telephone Number Fax				
Telephone Number TDD				
*Contact Name				
Telephone Number Contact	Telephone Number Extension			
Add Reset				
Continue Finish Later Cancel				

Once the address information is reviewed and updated as necessary, the user is required to select Verify Address. A pop up window will then appear asking to confirm the information. User can click on Select or User Original Address to complete the address information.

Address Verification: Results

To continue, select one of the options below.

Original Address

**Original address may be undeliverable.

Line 1 9850 Double R Blvd
Line 2 Suite 102
City Reno
State Nevada Zip+4 89521-0000
County Washoe

Use Original Address

Recommended Address Formatted for Deliverability

Click on **SELECT** to choose the address.

Address	City, State	County	ZipCode	Action
9850 DOUBLE R BLVD STE 102	RENO, Nevada	Washoe	89521-2987	Select

Cancel

Provider Addresses, continued

	Type	Street	City	State	Action
<input type="checkbox"/>	Service	5560 KIETZKE LN	RENO	Nevada	Copy Remove

***Address Type**

***Street**

***City** ***State**

***Zip+4** ***County**

[Verify Address](#)

Email Address **Confirm Email Address**

Telephone Number Office **Telephone Number Extension**

Telephone Number Fax

Telephone Number TDD

***Contact Name**

Telephone Number Contact **Telephone Number Extension**

[Save](#) [Reset](#) [Cancel](#)

<input type="checkbox"/>	Pay-To	BLDG A	RENO	Nevada	Copy Remove
<input type="checkbox"/>	Click to add address.				

[Continue](#) [Finish Later](#) [Cancel](#)

Once the address information has been verified, the active telephone number and contact information will have already populated.

All other fields are optional.

Once all fields have been populated, select the Save button.

Provider Addresses, continued

	Type	Street	City	State	Action
<input type="checkbox"/>	Service	9850 DOUBLE R BLVD STE 102	RENO	Nevada	Copy Remove
<input type="checkbox"/>	Click to add address.				

Continue

Finish Later

Cancel

The user can then select the + or the Copy link to add any additional address information pertaining to the Mail-To, Pay-To and Remittance Advice addresses.

Select Remove in order to delete an address.

Once all addresses have been completed, select Continue.

Provider Identification

Provider Legal Name

The legal name and Provider Federal Tax Identification Number (TIN) must match the information on the W-9, and is used by the Nevada Medicaid to generate the annual 1099 form for tax purposes.

*Provider Legal Name

NEVADA

Doing Business As
Name

The Provider Legal Name **must** match their W-9 form.

Doing Business As Name: If the provider will be operating the practice with a different name, list the DBA.

Provider Identification, continued

Special Ownership Type	
<p>*Is this entity owned or operated by the State of Nevada or any of its political subdivisions, e.g. state agency, county, entity or school district?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	
Special Ownership Type	<div><div></div><div></div></div>
NPI	County-owned
	Government-owned
The NPI is the National Prov	No owner
	Non-Profit
NPI	State-owned

ceived through the NPPES Registry for all healthcare providers.

If the practice will be owned or operated by a different entity than listed, select Yes. If Yes is selected, the Special Ownership Type will become a required field and an appropriate selection must be made from the drop-down menu.

If No is selected, user can move to the next question.

Provider Identification, continued

NPI
The NPI is the National Provider Identifier that is applied for and received through the NPPES Registry for all healthcare providers.
NPI 13

The provider’s NPI will already be pre-populated.

Provider Identification, continued

License			
*Name of Issuing Licensing Board, State or Entity		<input type="text" value="09-Other"/>	
*License Number		*License State	<input type="text" value="Nevada"/>
*Effective Date	<input type="text" value="03/13/2007"/>	*End Date	<input type="text" value="03/31/2019"/>

License Information: This information should be pre-populated and the user should still verify that the information is correct.

Provider Identification, continued

Business Information	
<div><div>*Nevada Secretary of State Issued Business ID</div><div><div></div></div></div>	<div><div>*Nevada Secretary of State Registered Name</div><div><div></div></div></div>
<div><div>*Choose the option that most closely describes the entity you are enrolling</div><div><div></div><div>Corporation</div><div>Indian Health Program (IHP)</div><div>Indian Health Services</div><div>Limited Liability Company</div><div>Limited Liability Partner</div><div>Non-Profit</div><div>Partnership</div><div>Provider Group</div><div>Sole Proprietorship</div></div></div>	
CLIA Certification	
<div><div>CLIA Number</div></div>	
Drug Enforcement Admin	

Business Information: This information may be pre-populated. If there is any missing information, user will need to complete the fields that still require an answer.

Provider Identification, continued

CLIA Certification	
CLIA Number	<input type="text"/>
Drug Enforcement Administration (DEA) Number	
DEA #	<input type="text"/>

CLIA (Clinical Laboratory Improvement Amendments) and DEA (Drug Enforcement Administration) Number: This information should be pre-populated for the user. If this information is not populated, the user will need to complete each field, if applicable.

Note: If the provider does not have either one of these pieces of information because lab tests are not being completed in office nor are pharmaceuticals being dispensed, the user can input a bypass code of nine 9s (999999999) into each field.

Provider Identification, continued

Taxonomy Codes

Choose your Taxonomy Codes

#	Taxonomy Codes	Action
<div>+</div>	208000000X - Pediatrics	Remove
<div>+</div>	Click to add new Taxonomy Code.	

Continue

Finish Later

Cancel

Providers are required to have a Taxonomy Code. Taxonomy Codes are determined by the provider and not Nevada Medicaid. Providers should review NPES for their registered Taxonomy Code. To add a Taxonomy Code, select the + symbol.

The Taxonomy Code should already be pre-populated. To add any additional Taxonomy Codes, select + to add.

Once all codes are input, select Continue.


Associated Providers

Provider Enrollment: Associated Providers






















[Welcome](#)
[Request Information](#)
[Specialties](#)
[Addresses](#)
[Provider Identification](#)
Associated Providers
EFT Enrollment
Other Information
Ownership & Disclosure
Agreement
Attachments
Summary

Select Add to add one or more associated individual providers to the group.

Providers affiliated with the group must be individual provider enrolled in the Nevada Medicaid program or have an application in process. The following form must be completed, including signature(s) and date(s) and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.

Associated Provider Signature Form [Download](#) 

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

	NPI	Provider Name	Action
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Associated Providers List

[illegible]

Each individual provider that will be linking to the group must complete this form, including a signature and the signature cannot be rubber stamped and must be physically signed. If there will be more than one (1) individual provider linking to the Group, each individual provider is able to sign the form. Once completed, upload the attachment which will be covered later in the training.

Associated Providers, continued

Associated Provider National Provider Identifier	
*NPI	<input type="text"/>
Associated Provider Individual Name.	
If the associated provider is an individual, enter their last name, first name and middle initial.	
Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle	<input type="text"/>
Associated Provider Business Name	
If the associated provider is a business, enter the business name.	
Business Name	<input type="text"/>
<input type="button" value="Add"/> <input type="button" value="Cancel"/>	

If adding new associated providers, complete the available fields and select Add


Associated Providers, continued

Provider Enrollment: Associated Providers

[Welcome](#)
[Request Information](#)
[Specialties](#)
[Addresses](#)
[Provider Identification](#)
Associated Providers
EFT Enrollment
Other Information
Ownership & Disclosure
Agreement
Attachments
Summary

Select Add to add one or more associated individual providers to the group.

Providers affiliated with the group must be individual provider enrolled in the Nevada Medicaid program or have an application in process. The following form must be completed, including signature(s) and date(s) and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.

Associated Provider Signature Form [Download](#) 


Click "+" to view or update the details in a row. Click "-" to collapse the row. Click the **Remove** link to remove the entire row.

NPI	Provider Name	Action
+ 1234512345	Provider	Remove
+ Click to add Associated Provider.		

[Continue](#) [Finish Later](#) [Cancel](#)

After all associated provider fields are completed and Add has been selected, repeat steps for any additional associated providers. After completing, select Continue.

EFT Information

Provider Enrollment: EFT Information ?	
Welcome	All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated or denied.
Request Information	
Specialties	
Addresses	
Provider Identification	
EFT Enrollment	Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Nevada Medicaid or the banking institution otherwise. I understand that Nevada Medicaid and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.
Other Information	If you have questions about completing the Electronic Funds Transfer Agreement, contact the Provider Enrollment Unit. If you have questions regarding your payment or the EFT program in general, contact the Customer Service Center. Both Nevada Medicaid departments may be contacted by phone at (877) 638-3472.
Ownership & Disclosure	You will need to attach a voided check, or a letter from your bank that contains your bank's routing number.
Agreement	
Attachments	Forms
Summary	<p>The EFT Authorization form must be completed, including a signature and date, and uploaded to this application using the Attachments page before being submitted. All documents must be uploaded at the time of provider enrollment form submission in order for your application to be processed and considered complete.</p> <p>EFT Authorization Download </p>
	Financial Institution Information
	<p>*Financial Institution Routing Number <input type="text"/></p> <p>*Provider's Account Number with Financial Institution <input type="text"/></p> <p>Reason For Submission <input type="text" value="New Enrollment"/></p> <p>*Include with Enrollment Submission <input type="text"/></p> <p>Requested EFT Start/Change/Cancel date 06/06/2019</p> <p>Continue Finish Later Cancel</p>

Providers will be asked to provide EFT information for Nevada Medicaid to make payments to the provider after claims processing.

Download the EFT Authorization, input the bank's Routing Number (9 digits), Account Number and indicate if attaching a Bank Letter or Voided Check. The date will auto-populate based on the effective date of the application that was completed previously and select Continue.

Note: EFT requests are not approved immediately. Nevada Medicaid is required to run "tests" to verify the bank information. EFT approvals can take up to 15 days.

EFT Information, continued

Nevada Medicaid and Nevada Check Up

If the provider has already enrolled in EFT, and the EFT information has remained the same, this form is not required. All providers must accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT). If a provider does not have an active EFT account enrolled with Nevada Medicaid, that provider's Nevada Medicaid enrollment may be terminated or denied.

Electronic Funds Transfer (EFT) Authorization: I hereby authorize Nevada Medicaid (Nevada Medicaid refers to the fiscal agent for Nevada Medicaid) and its subsidiaries to transfer my Nevada Medicaid and Nevada Check Up payments to the personal or business bank account shown below. I also authorize any necessary debit entries to correct payment errors. I understand the payments made through electronic funds transfers will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. This agreement will remain in effect until I notify Nevada Medicaid or the banking institution otherwise. I understand that Nevada Medicaid and/or my banking institution may also cancel this agreement at any time. All such cancellation notices must be made in writing and acted upon in a reasonable and timely manner.

Business or personal bank account number: _____

Authorized signature: _____ Date: _____

The EFT form must be completed and uploaded later in the application as an attachment and must accompany either a Bank Letter or a Voided Check.

TAPE AN ORIGINAL, VOIDED CHECK HERE



OR ATTACH A LETTER FROM YOUR BANK THAT CONTAINS YOUR BANK'S ROUTING NUMBER.

PHOTOCOPIED CHECKS AND BANK DEPOSIT SLIPS ARE NOT ACCEPTED.

Other Information

Additional Information	
*Are you enrolled in Medicare?	<input type="radio"/> Yes <input checked="" type="radio"/> No
*Days and Hours of Operation	<input type="text"/>
*Do you currently or will you provide service to recipients in the Fee For Service program, the Managed Care program or both?	<input type="text"/>
*Are you currently accepting new patients?	<input type="radio"/> Yes <input type="radio"/> No
*Can you accommodate recipients with special needs?	<input type="radio"/> Yes <input type="radio"/> No

Are you enrolled in Medicare: Select the appropriate answer. Later in the application there will be a similar question and both answers must match. If not, the application will be returned for corrections.

Days and Hours of Operation: Input days and time that the practice is open.

The next question will be selected from a drop-down menu and will indicate if the provider is seeing Fee For Service (FFS) recipients, Managed Care Organization (MCO) recipients or both FFS and MCO recipients. For more information regarding FFS and MCO recipients, please review the Billing Manual located on the Billing Information webpage of the Nevada Medicaid website.

Are you currently accepting new patients: Select the appropriate answer.

Can you accommodate recipients with special needs: Select the appropriate answer.

Other Information, continued

Subsidiary or Parent

Is the entity a subsidiary or parent of another entity? ☐ Yes ☐ No

If the Group is a subsidiary of another company or is the parent company to another entity, indicate Yes. If not, select No.

Other Information, continued

Facility Rating	
Facility Rating	<div><div></div><div>Profit</div><div>Non-Profit</div><div>Not applicable</div></div>
Facility Control	
Facility Control	

If there is a rating associated with the group, indicate the facility rating from the drop-down menu. If the group does not fall into one of the categories, select Not applicable or skip the question entirely.

Other Information, continued

Facility Control			
Facility Control			
Number of Beds			
Swing Bed	<input type="text"/>	Acute	<input type="text"/>
ICF			ISO <input type="text"/>
Mammography Certification Number (FDA-Certified m			

City

Charity

Not applicable

Private

Public

State

If there is another entity that will controlling the business, indicate an answer from the drop-down menu. If the group does not fall into one of the categories, select Not applicable or skip the question entirely.

Other Information, continued

Number of Beds											
Swing Bed	<input type="text"/>	Acute	<input type="text"/>	ICF	<input type="text"/>	SNF	<input type="text"/>	ICF/MR	<input type="text"/>	ISO	<input type="text"/>

If the facility will be issuing beds to patients, the amount of beds that are located in the facility must be indicated. If the facility has no beds, do not input any information into the fields.

Other Information, continued

Mammography Certification Number (FDA-Certified mammography providers only)	
Mammography Certification Number	<input type="text"/>
<div>Continue Finish Later Cancel</div>	

If the group will be performing Mammograms, the group must be FDA-Certified and the Certification Number must be listed. A copy of the certificate must be uploaded, which will be covered later in the training.

Ownership & Disclosure

Ownership Information

Completion of this section is a condition of participation in the Nevada Medicaid program and is mandated by 42CFR 7455.100 ? 106. Click [here](#) to view the full regulation

Ownership is defined as all individuals and corporations having direct or indirect ownership interest, or controlling interest in the disclosing entity (this includes relatives) and for any subcontracting company in which the disclosing entity has direct or indirect ownership of 5 percent or more. Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. Managing Employee is defined as a general manager, business manager, administrator, officer, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency. Board Member is defined as anyone who sits on a board of directors for any entity.

Information is required on the following:

- ▶ Group and Individual Enrollment applicants are required to enter all individuals or entities that:
 - ▶ have a direct or indirect ownership interest or controlling interest in the disclosing entity of 5 percent or more;
 - ▶ have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
 - ▶ owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - ▶ is an officer or director of a disclosing entity that is organized as a corporation; or
 - ▶ is a partner in a disclosing entity that is organized as a partnership.
- ▶ Group and Individual Enrollment applications are required to indicate the chain of ownership between the direct and indirect owners. Use the Related Corporations, Owners, Agents or Managing Employees Information grid below to indicate the chain of ownership.
- ▶ Group and Individual Enrollment applications are required to enter all Agents and Managing Employees.
- ▶ Group applications are required to enter all board member(s) if they are formed as a corporation.
- ▶ Anyone listed in the above entities that own 5 percent or more of any other business (health care related or non-health care related) is required to disclose that information.

Note: Owners are generally the Corporation or Owner entity types, but can also be board members/trustees. The information on ownership, board member(s), managing employee(s), and agent(s) needs to be added in the Ownership (Direct & Indirect) / Managing Employee grid below. Ownership information sent as an attachment will not be accepted.

This is not required for:

- ▶ Individuals linking to group
- ▶ Provider Type 38
- ▶ Groups and individuals with a Special Ownership type value of Government or State Owned selected on the Provider Identification panel

Note: County owned organizations, Non-Profit organizations, and school districts are required to disclose all Board Members and Managing Employees/Agents.

All providers must read and understand the instructions that are listed on this page in order to properly complete the application. Users should also refer to Chapter 2 Addendum of the OPE User Manual for clarification regarding information and formatting that must be followed in order to properly complete the application. If any information is incorrect, Nevada Medicaid will return the revalidation for review and corrections.

Users can also refer to Web Announcement 1899 at www.medicaid.nv.gov

Examples are outlined on the next three slides.

Ownership & Disclosure, continued

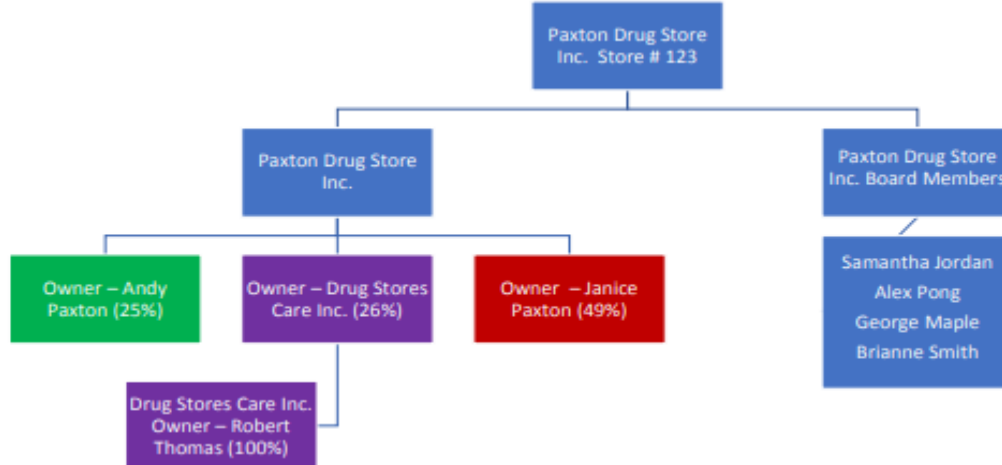
Chapter 2 Addendum. Ownership & Relationships Example

As part of the modernized Medicaid Management Information System (MMIS) update on February 1, 2019, providers are now required to identify all ownership in their company and outline the relationships that exist as outlined in Chapter 2 of the Online Provider Enrollment User Manual.

This process can be complex, so the purpose of this addendum is to provide an example.

2.1 Storyline

Paxton Drug Store #123 is completing their initial provider enrollment application. They are owned by Paxton Drug Store Inc. The parent company has four board members: Samantha, Alex, George and Brianne. Paxton Drug Store Inc. is owned by Andy Paxton, Janice Paxton and Drug Stores Care Inc. This company is owned by Robert Thomas.



2.2 Completing the Ownership Information Section

The provider must input all details regarding information:

- Paxton Drug Store owns 100% of Paxton Drug Store #123.
- Samantha Jordan, Alex Pong, George Maple and Brianne Smith are board members, but do not own any shares of the company.
- Andy Paxton owns 25% of Paxton Drug Store, Janice Paxton owns 49% and Drug Stores Care owns 26%.
- Robert Thomas owns 100% of Drug Stores Care.

Online Provider Enrollment User Manual, Chapter 2 Addendum
03/07/2019

1

Ownership & Disclosure, continued

Ownership Information

Completion of this section is a condition of participation in the Nevada Medicaid program and is mandated by 42CFR 7455.100 ? 106. Click [here](#) to view the full regulation

Ownership is defined as all individuals and corporations having direct or indirect ownership interest, or controlling interest in the disclosing entity (this includes relatives) and for any subcontracting company in which the disclosing entity has direct or indirect ownership of 5 percent or more. Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. Managing Employee is defined as a general manager, business manager, administrator, officer, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency. Board Member is defined as anyone who sits on a board of directors for any entity.

Information is required on the following:

- ▶ Group and Individual Enrollment applicants are required to enter all individuals or entities that:
 - ▶ have a direct or indirect ownership interest or controlling interest in the disclosing entity of 5 percent or more;
 - ▶ have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
 - ▶ owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - ▶ is an officer or director of a disclosing entity that is organized as a corporation; or
 - ▶ is a partner in a disclosing entity that is organized as a partnership.
- ▶ Group and Individual Enrollment applications are required to indicate the chain of ownership between the direct and indirect owners. Use the Related Corporations, Owners, Agents or Managing Employees Information grid below to indicate the chain of ownership.
- ▶ Group and Individual Enrollment applications are required to enter all Agents and Managing Employees.
- ▶ Group applications are required to enter all board member(s) if they are formed as a corporation.
- ▶ Anyone listed in the above entities that own 5 percent or more of any other business (health care related or non-health care related) is required to disclose that information.











Note: Owners are generally the Corporation or Owner entity types, but can also be board members/trustees. The information on ownership, board member(s), managing employee(s), and agent(s) needs to be added in the Ownership (Direct & Indirect) / Managing Employee grid below. Ownership information sent as an attachment will not be accepted.

This is not required for:

- ▶ Individuals linking to group
- ▶ Provider Type 38
- ▶ Groups and individuals with a Special Ownership type value of Government or State Owned selected on the Provider Identification panel

Note: County owned organizations, Non-Profit organizations, and school districts are required to disclose all Board Members and Managing Employees/Agents.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Ownership (Direct & Indirect) / Managing Employee					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
 1	Corporation	Paxton Drug Store	684864644	100	Remove
 2	Board Member/Trustee	Samantha Jordan	549227364	0	Remove
 3	Board Member/Trustee	Alex Pong	281228574	0	Remove
 4	Board Member/Trustee	George Maple	254681538	0	Remove
 5	Board Member/Trustee	Brianne Smith	425116842	0	Remove
 6	Owner	Andy Paxton	225683148	25	Remove
 7	Owner	Janice Paxton	254169841	49	Remove
 8	Corporation	Drug Stores Care	625479153	26	Remove
 9	Owner	Robert Thomas	259741258	100	Remove
	Click to add Type of Entity.				

2.3 Completing the Ownership or Controls Relationship Section

Now that all corporations, board members and owners have been input, the provider must link the people and/or corporations. This section does not include board members.

- Andy, Janice & Drug Stores Care are owners of Paxton Drug Store
- Andy is the spouse of Janice Paxton
- Robert Thomas owns Drug Stores Care

Online Provider Enrollment User Manual, Chapter 2 Addendum
03/07/2019

2

Ownership & Disclosure, continued

2.4 Note about Completing the Ownership Information Section

There may be times when ownership total does not equal 100%, as it did in Section 2.2, because some owners own less than 5% and would not be listed. When that happens, put detailed notes in the *Explanation if total ownership is less than* field.

There may also be times when the parent company is publicly traded and cannot provide people's names who own 5% or more of the company. In this situation, it is suggested to attach a letter explaining the circumstances to aid in processing the application more quickly.

Ownership or Control Relationships

In the Related Corporations Owners, Agents or Managing Employees Information grid below, indicate if any person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

Group and Individual Enrollment applications are required to use this grid to indicate the chain of ownership between the direct and indirect owners.

Is any person (individual or corporation) with an ownership or control interest in the disclosing entity related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or is any disclosed corporation an owner of any other disclosed corporation?

* ☒ Yes ☐ No

Related Corporations, Owners, Agents, or Managing Employees Information				
#	Corporation/Owner/Agent/Managing Employee Name	Relationship	Corporation/Owner/Agent/Managing Employee Name	Action
	Andy Paxton	Is The Owner Of	Paxton Drug Store	Remove
	Janice Paxton	Is The Owner Of	Paxton Drug Store	Remove
	Andy Paxton	Is The Spouse Of	Janice Paxton	Remove
	Drug Stores Care	Is The Owner Of	Paxton Drug Store	Remove
	Robert Thomas	Is The Owner Of	Drug Stores Care	Remove
	Click to add Relationship information.			

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Type of Entity Information					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
1	Owner	Mike Jones	123456789	92	Remove
2	Managing Employee	Sandy Smith	123456789	N/A	Remove
	Click to add Type of Entity.				

*Explanation if total ownership less than 100%

There are two people who own 4% each.

Ownership & Disclosure, continued

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicaid provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health-related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Ownership & Disclosure, continued

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.



Ownership & Disclosure, continued

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership & Disclosure, continued

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX of the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Ownership & Disclosure, continued

Person with an ownership or control interest means a person or corporation that:

- a) Has an ownership interest totaling 5 percent or more in a disclosing entity.
- b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- f) Is a partner in a disclosing entity that is organized as a partnership.

Ownership & Disclosure, continued

Subcontractor means:

- a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b) An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medical agreement.

Supplier means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmaceutical firm).

Ownership & Disclosure, continued

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
<div><div>Type of Entity</div><div>Title</div><div>Corporation Name</div><div>Ownership Type</div><div>Last Name</div><div>First Name</div><div>Middle</div><div>Birth Date</div><div>SSN</div><div>Federal Tax ID</div><div>Street</div><div>City</div><div>State</div><div>Zip+4</div><div>% of Ownership</div><div>Employee Indicator</div></div> <div>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</div> <div><input type="radio"/> Yes <input checked="" type="radio"/> No</div> <div><div>Add</div><div>Cancel</div></div>					

Type of Entity: This will be selected from a drop-down menu (Board Members/Trustee, Corporation, Managing Employee and/or Agent, or Owners). Depending upon the selection that is made, the questions may vary.

The next four slides cover the questions that must be answered depending on the Type of Entity selected.

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					

*Type of Entity: Board Member/Trustee

*Title:

*Last Name:

*First Name:

Middle: *Birth Date:

*SSN:

*Street:

*City:

*State: *Zip+4:

% of Ownership:

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* ☐ Yes ☒ No

If Board Member/Trustee is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* ☒ Yes ☐ No

Other Business Interests

#	Business Name	Federal Tax ID	Action
Click to add Other Business Interests.			

*Business Name:

*Federal Tax ID:

*Street:

*City:

*State:

*Zip+4:

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
<p>*Type of Entity <input type="text" value="Corporation"/></p> <p>*Corporation Name <input type="text"/></p> <p>*Ownership Type <input type="text"/></p> <p>*Federal Tax ID <input type="text"/></p> <p>*Street <input type="text"/> <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State <input type="text"/></p> <p>*Zip+4 <input type="text"/></p> <p>*% of Ownership <input type="text"/></p> <p>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</p> <p>* <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p>					

If Corporation is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

* ☐ Yes ☒ No

Other Business Interests

#	Business Name	Federal Tax ID	Action
Click to add Other Business Interests.			
<p>*Business Name <input type="text"/></p> <p>*Federal Tax ID <input type="text"/></p> <p>*Street <input type="text"/> <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State <input type="text"/></p> <p>*Zip+4 <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p>			

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					
<div><div>*Type of Entity</div><div>Managing Employees and/or Agent</div></div> <div><div>*Title</div><div></div></div> <div><div>*Last Name</div><div></div></div> <div><div>*First Name</div><div></div></div> <div><div>Middle</div><div></div><div><div>*Birth Date</div><div></div></div></div> <div><div>*SSN</div><div></div></div> <div><div>*Street</div><div></div><div></div></div> <div><div>*City</div><div></div></div> <div><div>*State</div><div></div><div><div>*Zip+4</div><div></div></div></div> <div><div>*Employee Indicator</div><div></div></div> <div><div>Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?</div><div><div>*Yes</div><div>*No</div></div><div><div>Add</div><div>Cancel</div></div></div>					

If Managing Employees and/or Agent is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?

*Yes

No

Other Business Interests

#	Business Name	Federal Tax ID	Action
Click to add Other Business Interests.			
<div><div>*Business Name</div><div></div></div> <div><div>*Federal Tax ID</div><div></div></div> <div><div>*Street</div><div></div><div></div></div> <div><div>*City</div><div></div></div> <div><div>*State</div><div></div></div> <div><div>*Zip+4</div><div></div></div> <div><div>Add</div><div>Cancel</div></div>			

Ownership & Disclosure, continued

Ownership (Direct & Indirect) / Managing Employee

#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
Click to add Type of Entity.					

*Type of Entity: Owners
*Title:
*Ownership Type:
*Last Name:
*First Name:
Middle: *Birth Date:
*SSN:
*Street:
*City:
*State: *Zip+4:
*% of Ownership:

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?
* ☐ Yes ☒ No

[Add](#) [Cancel](#)

If Owners is selected as the Type of Entity, the questions will be different. User must complete each question that is listed. If the user indicates Yes, that the entity owns more than 5% of any other business, additional questions must be answered.

Does this entity own 5 percent or more of any other business (health-care related or non health-care related)?
* ☒ Yes ☐ No

Other Business Interests

#	Business Name	Federal Tax ID	Action
Click to add Other Business Interests.			

*Business Name:
*Federal Tax ID:
*Street:
*City:
*State:
*Zip+4:

[Add](#) [Cancel](#)

Ownership & Disclosure, continued

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Ownership (Direct & Indirect) / Managing Employee					
#	Type of Entity	Legal Name	Federal Tax ID	% of Ownership	Action
<input type="checkbox"/> 1	Owner	First Last	111111111	90	Remove
<input type="checkbox"/> 2	Managing Employee	First Last	123333333	N/A	Remove
<input type="checkbox"/>	Click to add Type of Entity.				

Explanation if total ownership less than 100%

The percentage of ownership must equal 100%. If there are any owners of the business that own **less** than 5% of the practice, that information must be disclosed in the free form text field.

Ownership & Disclosure, continued

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

☒ Yes ☐ No

Mortgage, deed of trust, note or other obligation information				
#	Name	SSN	Federal Tax ID	Action
Click to add Individual and/or Corporation.				
<p>*Type of Entity <input type="text"/></p> <p>Name <input type="text"/></p> <p>Last Name <input type="text"/></p> <p>First Name <input type="text"/></p> <p>Middle <input type="text"/></p> <p>Birth Date <input type="text"/> <input type="text"/></p> <p>SSN <input type="text"/> Federal Tax ID <input type="text"/></p> <p>Street <input type="text"/></p> <p>City <input type="text"/></p> <p>State <input type="text"/></p> <p>Zip+4 <input type="text"/></p> <p>% of Ownership <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p>				

If any of the entities that were previously listed own more than 5% of a mortgage, deed, trust, note or other obligations, that information must be listed. The required fields will change depending on the Type of Entity selected.

If the entities do not own more than 5% of a mortgage, deed, trust, note or other obligations, the fields will not populate and user can move to the next question.

The next slide will show the different questions that must be answered depending upon the Type of Entity selected.

Ownership & Disclosure, continued

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

☒ Yes ☐ No

Mortgage, deed of trust, note or other obligation information				
#	Name	SSN	Federal Tax ID	Action
Click to add Individual and/or Corporation.				
<p>*Type of Entity Corporation</p> <p>*Name <input type="text"/></p> <p>*Federal Tax ID <input type="text"/></p> <p>*Street <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State </p> <p>*Zip+4 <input type="text"/></p> <p>*% of Ownership <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p>				

Does any individual and/or corporation have an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity?

☒ Yes ☐ No

Mortgage, deed of trust, note or other obligation information				
#	Name	SSN	Federal Tax ID	Action
Click to add Individual and/or Corporation.				
<p>*Type of Entity Owners</p> <p>*Last Name <input type="text"/></p> <p>*First Name <input type="text"/></p> <p>Middle <input type="text"/></p> <p>*Birth Date <input type="text"/></p> <p>*SSN <input type="text"/></p> <p>*Street <input type="text"/></p> <p>*City <input type="text"/></p> <p>*State </p> <p>*Zip+4 <input type="text"/></p> <p>*% of Ownership <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p>				

Ownership & Disclosure, continued

Ownership or Control Relationships

In the Related Corporations Owners, Agents or Managing Employees Information grid below, indicate if any person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

Group and Individual Enrollment applications are required to use this grid to indicate the chain of ownership between the direct and indirect owners.

Is any person (individual or corporation) with an ownership or control interest in the disclosing entity related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or is any disclosed corporation an owner of any other disclosed corporation?

☒ Yes ☐ No

Related Corporations, Owners, Agents, or Managing Employees Information

#	Corporation/Owner/Agent/Managing Employee Name	Relationship	Corporation/Owner/Agent/Managing Employee Name	Action
Click to add Relationship information.				
<div><div>*Corporation/Owner/Agent/Managing Employee Name</div><div>Is The</div><div>*Relationship (including Business Ownership)</div><div>Of</div><div>*Corporation/Owner/Agent/Managing Employee Name</div></div>				
<div>AddCancel</div>				

If any of the owners are related to one another, that information must be disclosed. Complete the fields and select Add. If there are no relationships between owners, indicate No and the fields will not appear.

Ownership & Disclosure, continued

Background and Disclosure of Disclosing Entity

These questions capture information regarding final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Who is authorized to make changes to enrollment and billing information?

Change Authorization Information

#	Legal Name	Action
<input type="button" value="Add"/>	Click to add Change Authorizations.	
<div><div>*Last Name</div><div><input type="text"/></div><div>*First Name</div><div><input type="text"/></div></div>		
<div><div>Add</div><div>Cancel</div></div>		

This question is regarding who in the practice is authorized to make changes on behalf of the provider. If information about a provider's profile must be changed and the user that is submitting the changes is not an authorized person, those changes cannot be made.

Changes can only be accepted from the Owner or the Authorized Representative.

Input the Authorized Representative's Last Name and First Name and select Add.

Ownership & Disclosure, continued

Are you or any owner, agent, managing employee, or person with controlling interest currently enrolled, or have ever been enrolled, as a Medicare or Medicaid provider with another state (including Nevada)?

* ☒ Yes ☐ No

Currently Enrolled or Previously Enrolled Information				
#	Program	State	Effective Date	Action
<div>Click to add Program.</div> <div><div>*Program</div><div></div></div> <div><div>*State</div><div></div></div> <div><div>*Effective Date</div><div></div></div> <div><div>Add</div><div>Cancel</div></div>				

If any owner, agent, managing employee or anyone else that has controlling interest in the practice has ever been enrolled in either Medicaid and/or Medicare, that information must be listed on the application and the answer to this question must match the similar question that was asked previously. Once fields are completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Do you or any owner, agent, managing employee or person with controlling interest currently have a negative balance or owe money to any state or federal program (including Medicare and Medicaid)?

* ☒ Yes ☐ No

Negative Balance/Owed Money Information				
#	Provider/Entity/Employee Name	Amount Owed	To Whom Is The Money Owed	Action
<div>Click to add Negative Balances.</div>				
<div><div>*Provider/Entity/Employee Name</div><div>*Amount Owed0.00</div><div>*To Whom Is The Money Owed</div><div><div>Add</div><div>Cancel</div></div></div>				

If any owner, agent, managing employee or person with controlling interest owes monies to a state and/or federal program, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been convicted of a misdemeanor, gross misdemeanor or felony, including but not limited to, criminal offenses related to any program under Medicare, Title XVIII, Title XIX or any Medicaid program since the inception of these programs?

* ☒ Yes ☐ No

Conviction Information

#	Name Used When Convicted	Date Of Conviction	Action
Click to add Convictions.			
	*Name Used When Convicted	*Date Of Conviction	
	*Charges		
	*Disposition		
	*Conditions Of Parole/Probation		

Add **Cancel**



If any owner, agent, managing employee or person with controlling interest has ever been convicted of a misdemeanor, gross misdemeanor or felony (see Chapter 100 of the Medicaid Services Manual for further clarification), all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended, terminated, denied or debarred from participation in any program established under Medicare, Medicaid, Title XVIII, Title XIX or any other Medicaid program since the inception of these programs? This includes termination from the Nevada Medicaid program or any other state Medicaid program.

* ☒ Yes ☐ No

Sanction Information						
#	Name Used When Sanctioned	Provider ID	Group ID	Sanction Effective Date	Reinstatement Date	Action
<div>Click to add OIG/HHS Sanctions.</div>						
<p>If no NPI/API, use IPN for either provider ID or Group ID number. Either provider ID or Group ID is required</p> <p>*Name Used When Sanctioned <input type="text"/></p> <p>Provider ID <input type="text"/></p> <p>Group ID <input type="text"/></p> <p>*Sanction Effective Date <input type="text"/> </p> <p>*Reinstatement Date <input type="text"/> </p> <div><input type="button" value="Add"/> <input type="button" value="Cancel"/></div>						

If any owner, agent, managing employee or person with controlling interest has ever been placed on the Office of Inspector General's exclusion list, all information must be disclosed. After all fields have been completed, select Add.

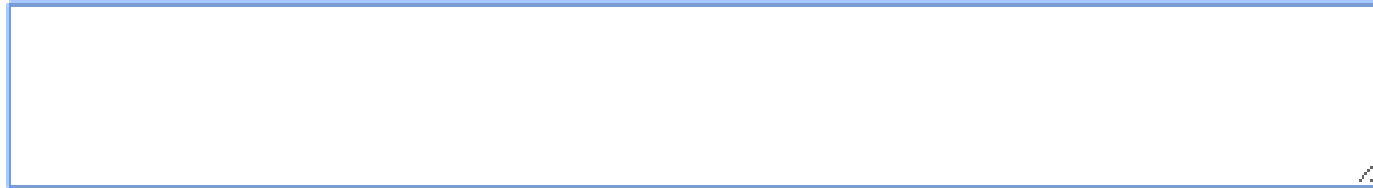
If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Are you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest currently under investigation by any law enforcement, regulatory or state agency?

* ☒ Yes ☐ No

*Please Provide Details



If any owner, agent, managing employee or person with controlling interest is currently under investigation, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Do you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest have any open or pending court cases?

* ☒ Yes ☐ No

*Please Provide Details
Including Court
Documentation

If any owner, agent, managing employee or person with controlling interest currently has an open or pending court case, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever been denied malpractice insurance?

* ☒ Yes ☐ No

* Explain

If any owner, agent, managing employee or person with controlling interest has been denied malpractice insurance, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked?

* ☒ Yes ☐ No

Denied, Suspended, Restricted or Revoked Professional License or Certificate Information			
#	Explanation	Denial/Suspension/Restriction/Revocation Dates	Action
<div>Click to add Surrendered Licenses.</div> <div><div><div>*Explanation</div><div></div></div><div><div>*From</div><div></div><div></div></div><div><div>*To</div><div></div><div></div></div></div> <div><div>Add</div><div>Cancel</div></div>			


If any owner, agent, managing employee or person with controlling interest has had their license denied, suspended, restricted or revoked, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Ownership & Disclosure, continued

Have you (individual or OPR provider), or any owner, agent, managing employee, or person with controlling interest ever voluntarily surrendered any professional license or certificate?

* ☒ Yes ☐ No

Voluntary Surrender of Professional License or Certificate Information			
#	Explanation	Voluntary Surrender Dates	Action
	Click to add denied, suspended, restricted or revoked information.		
	<p>*Explanation</p> <div></div>		
	<p>*From</p> <div></div>	<p></p> <div></div>	
	<p>*To</p> <div></div>	<p></p> <div></div>	
<div>Add</div> <div>Cancel</div>			

If any owner, agent, managing employee or person with controlling interest has voluntarily surrendered their license, all information must be disclosed. After all fields have been completed, select Add.

If answering No, select No and additional fields will not appear.

Agreement

Instructions

The terms of the request are outlined below. You must accept these terms in order to submit the request. Failure to accept these terms means that the request will not be submitted or saved.

Changes can be made to the existing request by going back to the appropriate screen using the links available on the left-hand side. Once changes are made, the request can be reviewed from the Summary Page after signing and continuing.

Once the request is submitted and confirmed, a tracking number will be assigned.

Note: The Nevada Medicaid and Nevada Check Up Provider Contract is required with every request. A link to this document is provided below.

There are three (3) sections of the Provider Enrollment: Agreement page. The first section is the Instruction section, which will provide instructions regarding the additional sections of the Agreement page. Providers must read and understand before proceeding with the remainder of the application.

Agreement, continued

Terms of Agreement

Provider Name

First Last

Street

9850 DOUBLE R BLVD STE 102
RENO
Nevada, 89521-2987

Employer Identification Number (EIN) or Social Security Number (SSN)

111111111

NPI

1234512345

Contact Name


First Last


Contact Email

email@domain.com

Please read and print for your records the Nevada Medicaid and Nevada Check Up Provider Contract. Please note that the Acceptance checkbox below will remain disabled until the provider contract document has been read.

Nevada Medicaid and Nevada Check Up Provider Contract

[Download](#) 



You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge as the Provider or legal representative of the provider, that you understand your electronic signature is binding to the same extent as your written signature.

***I accept the terms and conditions of the application and contract.**

☐

I understand that my electronic signature is equivalent to written signature.

***Provider or Authorized Representative Signature**

***Title**

Submission Date

06/10/2019

The second section of the Agreement page is the Terms of Agreement. The user must indicate that they accept the terms and condition (A) and complete the remaining fields.

In order to complete the section, the user **must** download the Nevada Medicaid and Nevada Check Up Provider Contract in order to be able to complete the question regarding the acceptance of the terms.

For this example, the question has been greyed out until the user downloads the contract. Once the contract has been downloaded, the question will then appear and can be answered.

Nevada Medicaid Provider Enrollment Training (Group Revalidation/Change)

83

Agreement, continued

Declaration
<p>I declare under penalty of perjury under the laws of the State of Nevada that the information in this document and any attachments are true, accurate and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the provider(s) listed on this Application. I understand that Nevada Medicaid will rely on this information in entering into or continuing a Nevada Medicaid Provider Contract and that this form will be incorporated into and become a part of my Nevada Medicaid Provider Contract. I understand that I am required to notify Nevada Medicaid within five days of changes to information on this Application. I understand that I am responsible for the presentation of true, accurate and complete information on all invoices/claims submitted to Nevada Medicaid. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.</p>
<div>Continue Finish Later Cancel</div>

The last section covers the Declaration, which indicates that the user has answered all questions to the best of their ability.

Once the Declaration is read and understood, select Continue.

Attachments

Provider Enrollment: Attachments ?

[Welcome](#)

[Request Information](#)

[Specialties](#)

[Addresses](#)

[Provider Identification](#)

[EFT Enrollment](#)

[Other Information](#)

[Ownership & Disclosure](#)

[Agreement](#)

Attachments

[Summary](#)

Supporting Documentation

Submit all of the required documentation and forms to continue the enrollment process.

- A checklist of required documentation can be found [here](#).

In addition to required documentation, additional supporting documentation can be uploaded with your application if necessary. If your responses to any questions on this enrollment application did not fit into the field on the page, type the question and response and upload the documentation using Other as the attachment type. All documents must be uploaded at the time of provider enrollment forms submission in order for your application to be considered complete. To upload the appropriate documents, follow the instructions under **Attachments** below.

Note: There is a maximum of 15 MBs of information when uploading attachments by **File Transfer**.

* Indicates a required field.

Provider Type and Specialty

Provider Type Physician, M.D., Osteopath, D.O.
Provider Specialty Allergy

Attachments -

To add an attachment to be uploaded with the enrollment form, select the File Transfer transmission type, click Browse..., select the file and then click **Add**.
Only allowed attachment types are .pdf files.
Use the "Other" attachment type to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
	*Transmission Method	FT-File Transfer ▼		
	*Attachment Type	▼		
	*Upload File	Choose File No file chosen		
<div>Add Cancel</div>				
<div>Continue Finish Later Cancel</div>				

The next section is where users will need to upload all required documents. Users will need to review the Enrollment Checklist for the Provider Type to determine if all documents have been uploaded.

Transmission Method will always default to FT-File Transfer and this does not need to be changed. Select the Attachment Type from the drop-down menu. Select Choose File and locate the appropriate document for uploading. Once the document is placed in the application, select Add.

Users will also need to make sure that the proper EFT documentation is also uploaded.

Once all applicable documents are uploaded, select Continue.

Summary

Instructions for Summary Page
<p>If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.</p> <p>Once you have reviewed the contents of this application, print a copy of this summary for your records, then select 'Confirm' to submit the enrollment for processing.</p>
<div>Print PreviewSave As PDFConfirmFinish LaterCancel</div>

The Summary page will allow users to view the information input into the application before submitting to Nevada Medicaid for approval.

Once the user reviews and determines that there are no changes necessary, select Confirm in order to submit to Nevada Medicaid for processing. After submitting, users can view the status of the application by logging into the OPE tool. Users will also receive mailed communication from Nevada Medicaid indicating whether or not the application has been accepted.

After submission, revalidations will be worked in the order they are received.

Resources

Resources

- Provider Enrollment Webpage: <https://www.medicaid.nv.gov/providers/enroll.aspx>
- Online Provider Enrollment Tool:
<https://www.medicaid.nv.gov/hcp42/provider/Home/tabid/477/Default.aspx>
- Ownership & Relationship Appendix (Chapter 2):
https://www.medicaid.nv.gov/Downloads/provider/NV_OPE_User_Manual_Ch2_Addendum.pdf
- Web Announcement 1899:
https://www.medicaid.nv.gov/Downloads/provider/web_announcement_1899_20190521.pdf
- Provider Billing Information: <https://www.medicaid.nv.gov/providers/BillingInfo.aspx>
- Medicaid Services Manual (Medicaid Policy):
<http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/>

Contact Nevada Medicaid



Contact Us – Customer Service

- Customer Service Call Center:
877-638-3472 (Monday through Friday 8 a.m. to 5 p.m. Pacific Time)
- Provider Field Representative:
Email: NevadaProviderTraining@dx.com



Thank You